Medlearn Matters
Information for Medicare Providers

Related Change Request (CR) #: 2617
Related CR Release Date: June 25, 2004
Related CR Transmittal #: 214
Effective Date: September 25, 2004
Implementation Date: September 25, 2004

Medlearn Matters Number: MM2617

MSN Messages for Mammography Claims, Pub 100-04, Chapter 18, Section 20 and Chapter 21, Section 50

Provider Types Affected

Providers and suppliers who bill for mammography services.

Provider Action Needed

Suppliers and providers should note that this article discusses changes in Medicare Summary Notice (MSN), which are sent to Medicare beneficiaries, and Remittance Advice messages and related situations where both film and digital screening mammography or film and digital diagnostic mammography are performed on the same day.

Background

Screening mammography tests can be performed by both film and digital technology. Because of this, some suppliers/providers have assumed the annual frequency rule did not apply in situations where both a film and digital screening is performed. That is not the case, however; Medicare will only pay for one screening test annually, whether performed by film or digital technology. Additionally, Medicare will pay only once for a screening test for a woman between the ages of 35 and 39. Further, Medicare will only pay for one mammography diagnostic test per day, not two.

The revised manual instructions include Medicare Claims Processing Manual updates regarding which Medicare Summary Notice (MSN) message and ANSI X-12 835[1] Adjustment Reason Code will be used on the Remittance Advice when Medicare denies a claim based on film and digital screening or film and digital diagnostic mammography services performed on the same day.

Currently, there are no established comparable MSN messages that can be used to explain why the claim is being denied. Without these new messages, beneficiaries would receive very general messages for denial of claims. The new MSN Messages are to be used when both film and digital screening

[1] American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X-12 transactions are part of the *Transactions and Code Sets Rule* selected by HIPAA.

mammography or film and digital diagnostic mammography has been performed on the same day. The Spanish translation for each new MSN messages has also been added to the revised manual.

Remittance Advice Messages

For providers/suppliers who bill carriers, the remittance advice messages will be as follows:

- If the claim is denied because two screening mammographies were performed on the same day, the claim will be denied with reason code *A1 "Claim Denied Charges,"* along with remark code *M90 "Not covered more than once in a 12 month period."*
- If the claim is denied because two diagnostic mammographies were billed on the same day, the claim is denied with reason code *A1 "Claim Denied Charges,"* along with remark code *M63 "Service denied because payment already made for same/similar procedure within set timeframe."*
- For claims submitted by a facility not certified to perform digital mammographies, the remittance advice will contain reason code *B6 "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty,"* along with remark code *N92 "This facility is not certified for digital mammography."*
- For claims that were submitted with an invalid or missing FDA identification number, use existing reason code *16 "Claim/service lacks information which is needed for adjudication,"* along with remark code *MA128 "Missing/incomplete/invalid six digit FDA approved identification number."*

Implementation

The implementation date of these changes is September 25, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services), Subsection 20.8 (Beneficiary and Provider Notices), Sub-subsections 20.8.1 (MSN Messages) and 20.8.2 can be found on the CMS Web site at:

http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR2617 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp